MARQUARDT
SCHOOL DISTRICT 15

STUDENT MEDICATION AUTHORIZATION FORM

(This side to be completed by physician or licensed provider)

TO: Marquardt School District 15
1860 Glen Ellyn Rd.
Glendale Heights, IL 60139

The following student is presently under my care. I believe that the failure of the student to receive the medication referenced herein, which I have prescribed, during the school day, would jeopardize the student's health and education.

Student's Name: _____ Birthdate: _____

Student's Address: _____ Phone No.: _____

School Attending: _____ Grade: _____

* * *

Name of Medication: _____

Dosage: _____ Time: _____

Purpose of Medication: _____

Reason for Medication: (condition or illness) _____

Possible Side Effects: _____

Additional Information_____

FOR ASTHMA MEDICATION AND/OR EPINEPHRINE AUTO-INJECTOR:
I give permission for my child to carry his/her inhaler and/or epinephrine auto-injector and be responsible in its use, provided the doctor gives consent for the same.
***Check one* _____ Yes _____ No**

Date: _____

Signature of Physician: _____

Name of Physician: _____

Street Address: _____

City/State/ Zip Code: _____

Office Phone Number: _____

Reviewed 07/20, 08/22, 2/24

MARQUARDT
SCHOOL DISTRICT 15

STUDENT MEDICATION AUTHORIZATION FORM

(This side to be completed by parent/ guardian)

TO: Marquardt School District 15
1860 Glen Ellyn Rd.
Glendale Heights, IL 60139

I, being the parent or guardian of the following named student, hereby request that School District 15 personnel administer prescription medication ordered by the student's physician or licensed prescriber in accordance with the letter that accompanies this form.

Student's Name: _____

Student's Address: _____

School Attended: _____

I understand that I am to bring in the medication to the school office in a pharmaceutical container labeled with the student's name, name of the medication, dosage and all pertinent instructions.

I hereby release School District 15, its officers, directors, agents, employees and assigns from any and all liability arising from the administration of medication to the above-named student.

I also acknowledge that the School District and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the student's self-administration of the medication. I agree to indemnify and hold harmless the School District and its employees and agents against any and all claims, except claims based on willful and wanton conduct, arising out of the self-administration of medication by the student.

FOR ASTHMA MEDICATION AND/OR EPINEPHRINE AUTO-INJECTOR:
I give permission for my child to carry his/her inhaler and/or epinephrine auto-injector and be responsible in its use, provided the doctor gives consent for the same.
***Check one* _____ Yes _____ No**

Date: _____

Signature of Parent/Guardian: _____

Name of Parent/Guardian: _____

Street Address: _____

City/State/ Zip Code: _____

Phone Number During School Hours: _____

Emergency Phone Number: _____

Reviewed 07/20, 08/22, 2/24